CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Administration and Financial Management

(Amended After Comments)

907 KAR 1:563. Medicaid covered services [~~hearings and~~] appeals and hearings unrelated to managed care**.**

RELATES TO: KRS Chapter 13B, 194A.025, 205.231, 205.237, 42 C.F.R. Part 475, 483.12, 431 Subpart E, 483 Subpart E, 42 U.S.C. 1396n(c)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(2) and (3), 205.6315, 42 U.S.C. 1396[~~(3), EO-2004-726~~]

NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.~~] The Cabinet for Health and Family Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds[~~for the provision of medical assistance to Kentucky's indigent citizenry~~]. This administrative regulation establishes policies and requirements[~~provisions~~] relating to an adverse action, an appeal, or a hearing regarding[~~the~~] Medicaid covered services that are not the responsibility of a managed care organization[~~hearing and appeal process for applicants and recipients~~].

Section 1. Definitions. (1) “1915(c) home and community based waiver service” means a service available or provided via a 1915(c) home and community based waiver services program.

(2) “1915(c) home and community based waiver services program” means a Kentucky Medicaid program established pursuant to and in accordance with 42 U.S.C. 1396n(c).

(3) "Applicant" means an individual who has applied for Medicaid covered services.

(4)[~~(2)~~] "Authorized representative" means**:**

(a) For a recipient or applicant who is authorized by Kentucky law to provide written consent, an individual or entity [~~or guardian~~] acting on behalf of, and with written consent from, **the[a]** recipient or **the** applicant**; or**

(b) A legal guardian.

(5) “Cabinet” means the Cabinet for Health and Family Services.

(6)[~~(3)~~] "Department" means the Department for Medicaid Services or its designee.

(7) “Enrollee” means a recipient who is enrolled with a managed care organization for the purpose of receiving Medicaid or Kentucky Children’s Health Insurance Program covered services.

(8) **“Final order” is defined by KRS 13B.010(6).**

(9) “Hearing” means cabinet level administrative hearing.

(10)[~~(9)~~] “ICF IID” means intermediate care facility for an individual with an intellectual disability.

(11)[~~(10)~~] "Managed care organization" or "MCO" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care

organization as defined in 42 C.F.R. 438.2.

(12)[~~(11)~~][~~(4)~~] "Medicaid covered services" means items or services a Medicaid recipient

may receive through the Medicaid Program.

(13)[~~(12)~~] "PASRR" means preadmission screening and resident review.

(14)[~~(13)~~] "Patient liability" means the financial obligation of a recipient towards the cost of the recipient's nursing facility services.

(15)[~~(14)~~] "Provider" is defined by KRS 205.8451(7).

(16)[~~(15)~~] "QIO" or "quality improvement organization" means an entity that meets the requirements established in 42 C.F.R. 475.101.

(17)[~~(16)~~] "Recipient" is defined by KRS 205.8451(9).

(18) "Recommended order" is defined by KRS 13B.010(5).

(19)[~~(17)~~][~~(5) "Member" means a Medicaid recipient who is enrolled in a partnership or a managed behavioral healthcare organization.~~

~~(6) "Peer review organization" means a federally designated organization that is performing the utilization review functions for the department.~~

~~(7) "Recipient" means an individual who receives Medicaid.~~

~~(8)~~] **["Secretary" means the Secretary of the Cabinet for Health and Family Services.~~**

~~(18)~~][~~(9)~~] "Time-limited benefits" means Medicaid coverage which is restricted to a specified period in time.

Section 2. Informing the Recipient of Medicaid Coverage Hearing Rights. (1) An applicant, recipient, or authorized representative[~~guardian~~] shall be informed, in writing,

of the applicant's or recipient's right to a hearing[of his right to a cabinet level administrative hearing in writing] if an adverse action is taken affecting covered services.

(2) An applicant, recipient, or authorized representative[guardian] shall be informed of the method by which the applicant or recipient[he] may obtain a hearing and that the applicant or recipient[he] may be represented by:

(a) Legal counsel;

(b) A relative;

(c) A friend;

(d) A[Other] spokesperson not listed in paragraph (a), (b), (c), (e), or (f);

(e) An authorized representative; or

(f) Himself or herself.

(3) An adverse action[The] notice shall contain a statement of:

(a) The Medicaid adverse action;

(b) The reason for the action;

(c) The specific federal or state law or administrative regulation that supports the action; and

(d) An explanation of the circumstances under which payment for services shall be continued if a hearing is requested in a timely manner pursuant to[timely in accordance with] Section 5 of this administrative regulation.

Section 3. Notification Process. (1) An adverse action notice regarding an applicant or a recipient shall be mailed to the applicant, recipient, or authorized representative of the applicant or recipient using:

(a) The United States Postal Service; and

(b) A return receipt requested format.

(2) Refusal by an applicant, a recipient, or an authorized representative to confirm receipt of an adverse action notice shall be considered receipt of the adverse action notice.[~~an applicant or a recipient using the United States Postal Service.~~

~~(2) An adverse notice to an applicant, recipient or responsible party covered under Section 5(1) of this administrative regulation shall be sent using a return receipt requested format.~~]

Section 4. Request for a Hearing. (1) An applicant, recipient, or an authorized representative may request a hearing by filing a written request with the department.

(2) If an applicant, recipient, or authorized representative requests a hearing, the request shall:

(a) Be in writing and clearly specify the reason for the request;

(b) Indicate the date of service or type of service for which payments may be denied; and

(c) Be postmarked within thirty (30) calendar days from the date of the department's written notice of adverse action of:

1. Discontinuance of services;

2. Adverse determination made with regard to the PASRR requirements of 42 U.S.C. 1396r(e); or

3. Patient liability.

Section 5. Continuation of Medicaid Covered Services. (1)**(a) Except as established in paragraphs (b) or (c) of this subsection or subsections (2), (3), or (4) of this**

section, if a[~~the~~] request for a [~~cabinet level administrative~~] hearing is postmarked or received within ten (10) days of the advance notice date of denial **[~~for any of the following types of denials~~]**, the individual shall remain eligible for the care, program participation, or service denied until the date that the final **[~~hearing decision~~]** order is rendered in accordance with Section 9 of this administrative regulation.

(b) The individual shall not remain eligible for the care, program participation, or service denied if:

1.a. It is determined at the hearing that the sole issue is one of federal or state law or policy; and

b. The department promptly informs the individual in writing that the services shall be terminated or reduced pending the hearing decision;

2. The individual's eligibility for time-limited benefits has expired; or

3. The individual has already received in full the specified amount of care or number of services that were authorized by the department.

(c) A request for an amount of care or number of services subsequent to receiving a previously authorized amount of care or number of services in full shall not be considered a continuation of the previously authorized amount of care or number of services.[~~:~~

~~**(a) Denial that an individual meets patient status criteria to qualify for nursing facility services pursuant to 907 KAR 1:022;**~~

~~**(b) Denial that an individual meets patient status criteria to qualify for ICF-IID services pursuant to 907 KAR 1:022;**~~

~~**(c) Denial that an individual meets nursing facility level of care criteria, nursing**~~

facility patient status criteria, or ICF IID patient status criteria pursuant to 907 KAR 1:022 to qualify for home and community based waiver services; or

(d) Denial of a home and community based waiver service][specified on the notice for denial of level of care, a Medicaid vendor payment for nursing facility, intermediate care facility for the mentally retarded and developmentally disabled, or home- and community-based waivers services shall continue until the date the final cabinet level hearing decision order is rendered in accordance with Section 9 of this administrative regulation.**]**

(2)**[Subsection (1) of this section shall not apply to a Medicaid Program service not stated in subsection (1) of this section.**

(3)] Subsection (1) of this section shall not apply if the Medicaid Program service has been reduced or discontinued as a result of a change in law or administrative regulation.

(3)[(4)] Time-limited benefits shall not be extended based on a request for a hearing.

(4)[(5)] If a request for a[the request for a cabinet level administrative] hearing is postmarked or received from a recipient within ten (10) days of the advance notice of an adverse PASRR determination made in the context of a resident review, the department shall continue to reimburse[a Medicaid vendor payment] for nursing facility services [shall continue] until the date that the final **order**[the cabinet level administrative] **[hearing decision]** is rendered.

Section 6. Notice of Scheduled Hearing. (1) A[The] scheduled hearing notice shall contain:

(a) The date, time, and place of the scheduled hearing; and

(b) A statement that the local Department for Community Based Services[Social

~~Insurance~~] office provides information regarding the availability of free representation by legal aid or a welfare rights organization within the community.

(2)(a) A [~~cabinet level administrative~~]hearing shall be conducted within thirty (30) days of the date of the request for a hearing.

(b) [~~and~~] A decision shall be issued within thirty (30) days of the hearing date, except for a hearing decision regarding:

1. A nursing facility level of care or patient status decision;

2. An ICF IID patient status decision;

3. A nursing facility level of care, nursing facility patient status, or ICF IID patient status decision related to 1915(c) home and community based waiver program participation; or

4. A 1915(c) home and community based waiver service.

(c) A hearing decision regarding an item listed in paragraph (b) of this subsection shall be issued within fifteen (15) calendar days of the date of request for the hearing[~~that a hearing decision regarding vendor payments to the following shall be issued within fifteen (15) days:~~

~~(a) Nursing facilities;~~

~~(b) Intermediate care facility for the mentally retarded and developmentally disabled;~~ ~~or~~

~~(c) Community based waiver services~~].

(3) An applicant or recipient shall receive notice consistent with KRS 13B.050 including the right to:

(a) Legal counsel or other representation;

(b) Review the case record relating to the issue; and

(c) Submit additional information in support of the applicant's or recipient's[~~his~~] claim.

(4) If a[~~the~~] hearing involves medical issues:

(a) A medical assessment by an independent physician participating in the Medicaid Program shall be obtained at the department's expense if the hearing officer considers it necessary based on case record review;

(b) If an independent physician assessment at the department's expense is requested by the recipient or authorized representative and is denied by the hearing officer, notification of the reason for denial shall be established[~~set forth~~] in writing.

Section 7. Conduct of a Hearing. (1) A[~~The cabinet level administrative~~] hearing shall be conducted in accordance with the requirements of KRS 13B.080 and 13B.090.

(2) A[~~Impartiality. The cabinet level~~] hearing officer shall be impartial and shall disqualify himself or herself as required by KRS 13B.040.

(3) A[~~The cabinet level administrative~~] hearing shall be conducted in-state where the recipient or authorized representative may attend without undue inconvenience.

(4) A[~~The~~] hearing officer shall offer to transmit a[~~the~~] hearing decision by electronic format.

(5) If necessary to receive full information on the issue, a[~~the administrative~~] hearing officer may examine each party who appears and the party's[~~his~~] witnesses.

(6)(a) A[~~The administrative~~] hearing officer may reopen the hearing and take additional evidence as is deemed necessary.

(b) Evidence shall be taken in accordance with the provisions of KRS 13B.080 and 13B.090.

Section 8. Withdrawal or Abandonment of Request. (1) A[~~The~~] recipient or authorized representative:

(a) May withdraw the appeal for a hearing prior to the release of the hearing officer's decision; and

(b) Shall be granted the opportunity to discuss withdrawal with the recipient's[~~his~~] legal counsel or authorized representative prior to finalizing the action.

(2) [~~Abandonment of request. ~~]A hearing request shall be considered abandoned if the recipient or authorized representative fails without prior notification to report for the hearing.

Section 9. **Recommended Order[~~The Cabinet Level Decision~~]**. (1) After a[~~the~~] hearing is concluded, the hearing officer shall issue a recommended **order[~~decision~~]**.

(2) **[~~If a party wishes to file an exception, the exception~~[~~Exceptions] shall be filed with the cabinet within fifteen (15) days from the recommended decision.~~**

~~(3) A final order shall be issued within ninety (90) days from the date of the request for a hearing.~~

~~(4)~~] A copy of the recommended **order[~~decision~~]** and a copy of the final order shall be mailed to the recipient and the recipient's authorized representative if applicable[~~his representative~~].

(5) If requested during the hearing, a copy of the recommended **order[~~decision~~]** and the final order shall be electronically transmitted to a site specified by the applicant or recipient on the:

(a) Date the recommended **order[~~decision~~]** is rendered; and

(b) Date the final order is rendered.[~~dates the recommended decision is rendered and~~

~~the date the final order is rendered to a site specified by the applicant or recipient~~].

Section 10. Appeal of **Recommended Order**[~~Cabinet Level~~] **[~~Hearing Decision~~]**. (1) A[~~The~~] final order, with respect to the issue considered, shall be final regarding continuation of a service or service reimbursement[~~vendor payments~~].

(2) **If a party wishes to file an exception to the recommended order, the exception shall be filed with the cabinet within fifteen (15) days from the date that the recommended order is mailed.**

(3) A final order shall be issued within ninety (90) days from the date of the request for a hearing.

(4)(a) In accordance with 42 C.F.R. 431.233, an applicant or recipient shall have a right to request a:

1. Cabinet level review of the record of the hearing; or

2. De novo hearing at which the party may offer:

a. Evidence not presented at the hearing below; and

b. The evidentiary record of the fair hearing.

(b) If the applicant or recipient does not specifically request a de novo hearing, the cabinet level review shall determine whether the:

1. Recommended order was supported by substantial evidence in the record; and

2. Law was applied correctly.

(5) A further appeal at the circuit court level may be initiated within thirty (30) days from the date of mailing of the **final order[~~decision~~]** in accordance with KRS 13B.140 and 13B.150.

(6)[~~(3)~~] Information regarding free legal aid and welfare rights organizations may be

obtained in accordance with Section 6(1) of this administrative regulation.

Section 11. Medicaid Case Actions Following Circuit Court Level Appeal Decision.

(1) For a reversal involving a reduction of Medicaid coverage, action shall be taken to restore services within ten (10) days of the receipt of the circuit court decision.

(2) If a recipient continues to:

(a) Remain in a nursing facility or an ICF IID during the circuit court appeal process, the department shall reimburse for the nursing facility services or ICF IID services which occurred during the circuit court appeal process; or

(b) Receive a 1915(c) home and community based waiver service during the circuit court appeal process, the department shall reimburse for the service which occurred during the circuit court appeal process.[~~remain in or continue to receive services from a nursing facility, intermediate care facility for the mentally retarded and developmentally disabled, or community-based waiver services, a vendor payment shall be authorized to reimburse the provider for services rendered during the circuit court appeal process~~].

Section 12. Special Procedures Relating to a Managed Care Participant. (1) For an adverse action toward an enrollee regarding a service that is within the scope of managed care, the requirements governing the MCO internal appeal process and the department's **[~~state fair~~]** hearing process for the enrollee shall be as established in 907 KAR 17:010.

(2) For an adverse action by the department toward an enrollee regarding a service that is not within the scope of managed care, the appeals policies and requirements established in this administrative regulation shall apply.[~~Special Procedures Relating to A Managed Care Participant. (1) A Medicaid recipient shall be~~

~~informed in writing of the requirements for making a complaint, filing a grievance and requesting a hearing:~~

~~(a) By the partnership in which a member is enrolled in accordance with 907 KAR 1:705; and~~

~~(b) By the managed behavioral healthcare organization in which a member is enrolled in accordance with 907 KAR 1:710.~~

~~(2) If the decision of the partnership or the managed behavioral healthcare organization is adverse to the member, the member or his authorized representative:~~

~~(a) May request a hearing regarding the action or inaction on the part of the partnership, the managed behavioral healthcare organization or its subcontracted provider to the department in accordance with Section 3 of this administrative regulation; and~~

~~(b) Shall not be required to employ or exhaust the other complaint or grievance resolution processes contained within the partnership or managed behavioral healthcare organization plan.~~

~~(3) A cabinet level appeal shall be processed as established in Sections 3, 4, 6, 7, 8, and 9 of this administrative regulation.~~]

Section 13. Limitation of Fees. (1) Pursuant to KRS 205.237, the maximum fee that an attorney may charge the applicant or recipient for the representation in all categories of Medicaid shall be:

(a) Seventy-five (75) dollars for preparation and appearance at a hearing before a hearing officer;

(b) $175 for preparation and presentation, including a pleading and appearance in

court, of an appeal to the circuit court; or

(c) $300 for preparatory work and briefs and all other matters incident to an appeal to the Court of Appeals.

(2)(a) Enforcement of payment of a fee shall:

1. Not be a matter for the department or the cabinet; and

2. Be a matter between the counsel or agent and the recipient.

(b) The fee [~~shall be a matter entirely between the counsel or agent and the recipient. The fee~~] shall not be deducted from a public assistance payment otherwise due and payable to the recipient.

(3)(a) The fee limitations stated in subsection (1) shall:

1. Apply to the amount an attorney may charge a recipient or applicant; and

2. Not apply to the amount an attorney may collect from another entity or person who represents the recipient or applicant in all categories of Medicaid.

(b) The amount an attorney may collect from an entity or person who is not a recipient or applicant for representing the recipient or applicant in all categories of Medicaid shall:

1. Be a matter between the attorney and other entity or person; and

2. Not be a matter that involves the department or cabinet.

Section 14. A hearing or an appeal relating to a decision to reclassify or transfer a person with an intellectual disability[~~mental retardation~~] in a state institution shall be in accordance with the requirement of KRS 210.270.

Section 15. Burden of Proof. The party bearing the burden of proof shall be determined in accordance with KRS 13B.090(7).

907 KAR 1:563

REVIEWED:

Date	Lawrence Kissner, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynes, Secretary Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:563
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes Medicaid program policies and requirements regarding covered services hearings and appeals for the Medicaid population.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid program policies and requirements regarding covered services hearings and appeals for the Medicaid population.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of authorizing statutes by establishing Medicaid program policies and requirements regarding covered services hearings and appeals for the Medicaid population.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statutes by establishing Medicaid program policies and requirements regarding covered services hearings and appeals for the Medicaid population.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendment replaces the reference to an obsolete agency, Department for Social Insurance, with the current hearing agency; establishes that state fair hearings (cabinet level hearings) requirements for managed care enrollees and managed care appeals requirements for managed care enrollees shall be as established in another administrative regulation (907 KAR 17:010, Managed care organization requirements and policies relating to enrollees); inserts definitions for clarity and clarifies policies; and contains language and formatting revisions to comply with KRS Chapter 13A as this administrative regulation has not been amended since 1993. The amendment after comments alters the definition of “authorized representative” to include legal guardians as authorized representatives and to clarify that written consent is required for individuals who are permitted by Kentucky law to provide written consent. The amendment after comments establishes that the option to continue to receive services during an appeal process exists for individuals unless it’s determined at the hearing that the sole issue is one of federal or state law or policy and the Department for Medicaid Services (DMS) informs the individual in writing that services will be terminated or reduced pending the hearing decision [this mirrors the federal requirement stated in 42 C.F.R.

431.230(a)(1)], the individual's eligibility for time-limited Medicaid benefits has expired, or the individual has already received the specified amount of care or services authorized by the department. The amendment after comments elaborates by establishing that a request for an amount of care or services subsequent to receiving a previously authorized amount in full shall not be considered a continuation of the previously authorized amount of services. The prior version of the administrative regulation stated that continuation of services during an appeal was only available regarding nursing facility services, home and community based waiver services, and services provided in an intermediate care facility for individuals with an intellectual disability. The amendment after comments also adds a subsection regarding the maximum amount an attorney can charge a Medicaid recipient or Medicaid applicant for representing the recipient/applicant. The new subsection establishes that the amount an attorney may collect from an entity or person (other than the recipient or applicant) is not subject to the limit established for applicants/recipients, is a matter between the attorney and other entity/person, and is not a matter that involves DMS or the Cabinet for Health and Family Services. Additionally, the amendment after comments changes the term "final hearing decision" to "final order" and "recommended decision" to "recommended order" (and inserts a definition for each term) as those are the terms used in the applicable statute – KRS 13B.010, moves two (2) provisions regarding appeals of a recommended order from Section 9 to Section 10 as Section 10 is a more appropriate locale for the provisions, removes the definition of "secretary" as the term is not used in the administrative regulation, and inserts an option for a recipient to request a de novo hearing/review of the record of a hearing.

(b) The necessity of the amendment to this administrative regulation: The amendment regarding managed care enrollee appeals and state fair hearings (cabinet level hearings) is necessary as a new administrative regulation now establishes those policies and requirements; some amendments are necessary to clarify policy; some amendments are necessary to ensure that language and formatting comply with KRS Chapter 13A standards; and one amendment (replacing the agency title Department of Social Insurance with Department for Community Based Services) is necessary to correct an obsolete reference. The amendment after comments is necessary to accommodate scenarios where an individual is prohibited by Kentucky law from granting written consent to another individual (due to not being deemed competent of doing so.) The amendment after comments regarding continuation of services during an appeal is necessary to maintain conformity with federal requirements. The amendment after comments that allows an attorney to collect, from an entity or individual other than the Medicaid recipient or applicant, an amount higher than the limit imposed on what can be collected of recipients or applicants is necessary to accommodate scenarios where an individual or entity chooses to represent an applicant or recipient and pay the attorney fees. The amendments after comments which changes the term "final hearing decision" to "final order" and "recommended decision" to

"recommended order" are necessary to ensure consistency with the applicable statute – KRS 13B.010. The amendment regarding a de novo hearing/review of the record of a hearing is necessary to comport with the federal requirement.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by clarifying policy and revising language and formatting to ensure that it complies with KRS Chapter 13A standards. The amendment after comments conforms to the content of the authorizing statutes by accommodating scenarios where an individual is prohibited by Kentucky law from granting written consent to another individual (due to not being deemed competent of doing so.) The amendment after comments conforms to the content of the authorizing statutes by ensuring conformity with federal requirements, enhancing the ability for entities or individuals to represent Medicaid applicants or recipients (and assume the legal costs), and to ensure consistency of the term "final order" and "recommended order" to ensure consistency with the applicable statute.

(d) How the amendment will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statues by clarifying policy and revising language and formatting to ensure that it complies with KRS Chapter 13A standards. The amendment after comments will assist in the effective administration of the authorizing statutes by accommodating scenarios where an individual is prohibited by Kentucky law from granting written consent to another individual (due to not being deemed competent of doing so.) The amendment after comments will assist in the effective administration of the authorizing statutes by ensuring conformity with federal requirements, enhancing the ability for entities or individuals to represent Medicaid applicants or recipients (and assume the legal costs), and to ensure consistency of the term "final order" and "recommended order" with the applicable statute.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation affects recipients of Medicaid services.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: A recipient who wishes to appeal a Medicaid service denial shall comply with the appeal provisions established in this administrative regulation.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): DMS anticipates no cost imposed by the amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The clarifications should benefit recipients in being able to better understanding the appeals policies and requirements.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: DMS anticipates that the amendment to this administrative regulation will not result in additional costs to the department.
(b) On a continuing basis: DMS anticipates that the amendment to this administrative regulation will not result in additional costs to the department.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Sources of funding to be used for the implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and agency appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: This administrative regulation does not impose or increase any fees.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment does not establish or increase any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Tiering was not appropriate in this administrative regulation because the administration regulation applies equally to all those individuals or entities regulated by it.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 1:563
Contact Person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation?

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS Chapter 13B, KRS 194A.030(2), 194A.050(1), 205.231, 205.237, 205.520(3), 42 C.F.R. 431 Subpart E and 42 C.F.R. 483 Subpart E.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The Department for Medicaid Services (DMS) anticipates no revenue for state or local government will result from the amendment.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS anticipates no revenue for state or local government will result from the amendment.
   (c) How much will it cost to administer this program for the first year? DMS anticipates no cost as a result of the amendment including the amendment after comments.
   (d) How much will it cost to administer this program for subsequent years? DMS anticipates no cost as a result of the amendment including the amendment after comments.
   Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

   Revenues (+/-): ____
   Expenditures (+/-): ____
   Other Explanation: No additional expenditures are necessary to implement this amendment.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:563
Contact Person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 C.F.R. 431 Subpart E, 42 C.F.R. and 483 Subpart E.

2. State compliance standards. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry.

   KRS 194A.050(1) requires the cabinet secretary to "formulate, promote, establish, and execute policies, plans, and programs and shall adopt, administer, and enforce throughout the Commonwealth all applicable state laws and all administrative regulations necessary under applicable state laws to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the Commonwealth and necessary to operate the programs and fulfill the responsibilities vested in the cabinet. The secretary shall promulgate, administer, and enforce those administrative regulations necessary to implement programs mandated by federal law, or to qualify for the receipt of federal funds and necessary to cooperate with other state and federal agencies for the proper administration of the cabinet and its programs."

   KRS 205.237 establishes that "any individual claiming public assistance in any proceeding before the appeal board or a court may be represented by counsel; but no counsel shall either charge or receive for such service more than an amount established by the secretary by administrative regulation."

   KRS 205.231 establishes appeals, hearing officer and related provisions as follows: "(1) The secretary shall appoint one (1) or more impartial hearing officers to hear and decide upon appealed decisions.

   (2) Any applicant or recipient who is dissatisfied with the decision or delay in action on his application for public assistance or the amount granted to him may appeal to a hearing officer, except that an appeal and a hearing need not be granted if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients of the Kentucky medical assistance program so long as advance notice of the change, with an explanation of appeal rights, is provided to all affected recipients. However, a recipient may appeal whether the cabinet is accurately interpreting a change in federal or state law which may adversely affect the recipient. On receipt of an appeal, an administrative hearing shall be conducted in accordance with KRS Chapter 13B.

(3) The secretary may appoint an Appeal Board for Public Assistance composed of the secretary and two (2) other members. The secretary shall be chairman, and he and one (1) other member constitute a quorum.

(4) Any applicant or recipient who is dissatisfied with the decision of a hearing officer may appeal to the appeal board in the manner and form prescribed by administrative regulation. The board may on its own motion affirm, modify, or set aside any decision of a hearing officer on the basis of the evidence previously submitted in the case, or direct the taking of additional evidence, or may permit any of the parties to the decision to initiate further appeals before it. The board may remove itself or transfer to another hearing officer the proceedings on any appeal pending before a hearing officer. The board shall promptly notify the parties to any proceedings of its findings and decisions.

(5) The manner in which appeals are presented and hearings and appeals conducted under subsection (4) of this section shall be in accordance with administrative regulations promulgated by the secretary.

(6) After a decision by the appeal board, any party aggrieved by the decision may seek judicial review of the decision by filing a petition in the Circuit Court of the county in which the petitioner resides, in accordance with KRS 13B.140, 13B.150, and 13B.160."

3. Minimum or uniform standards contained in the federal mandate. 42 C.F.R. 431, Subpart E requires the Medicaid program's hearing system to provide for a hearing before the agency or an evidentiary hearing at the local level, with a right of appeal to a State agency hearing and the hearing system must meet the due process standards established in *Goldberg v. Kelly,* 397 U.S. 254 (1970), and any additional standards specified in 42 C.F.R. 431, Subpart E. Additionally, the Medicaid program must satisfy various notice requirements as well as hearing conduct requirements among other related requirements.

   Included among the requirements in 42 C.F.R. 431, Subpart E are the following regarding the right to continue to receive services pending an appeal of denied services:

   42 C.F.R. 431.220 states the following:
   "(a) The State agency must grant an opportunity for a hearing to the following:
   (1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness.
   (2) Any recipient who requests it because he believes the agency has taken an action erroneously.
   (3) Any resident who requests it because he or she believes a skilled nursing facility or nursing facility has erroneously determined that he or she must be transferred or discharged.

(4) Any individual who requests it because he or she believes the State has made an erroneous determination with regard to the preadmission and annual resident review requirements of section 1919(e)(7) of the Act.
(5) Any MCO or PIHP enrollee who is entitled to a hearing under subpart F of part 438 of this chapter.
(6) Any PAHP enrollee who has an action as stated in this subpart.
(7) Any enrollee who is entitled to a hearing under subpart B of part 438 of this chapter.
(b) The agency need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients."

42 C.F.R. 431.230 states the following:

"(a) If the agency mails the 10-day or 5-day notice as required under §431.211 or §431.214 of this subpart, and the recipient requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless—
(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and
(2) The agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.
(b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section."

42 C.F.R. 483, Subpart E requires the Medicaid program to provide a system for a resident of a skilled nursing facility (SNF) or a nursing facility (NF) to appeal a notice from the SNF or NF of intent to discharge or transfer the resident, and for an individual adversely affected by any pre-admission screening resident review (PASRR) determination made by the State in the context of either a preadmission screening or an annual resident review under subpart C of part 483 to appeal that determination. Additionally, the Medicaid program must provide an appeals system that meets the requirements of this 42 C.F.R. 483, Subpart E and 42 C.F.R. 431, Subpart E.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? This amendment does not impose stricter, than federal, requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This amendment does not impose stricter, than federal, requirements.